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	155636	A. BUILDING 00 B. WING	01/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON TERRACE	1924 WELLESLEY BLVD INDIANAPOLIS, IN 46219

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F0000	This visit was for the Investigation of Complaint IN00121723. This visit resulted in a partially-extended survey - Immediate Jeopardy. Complaint IN00121723 - Substantiated. Federal/state deficiencies related to the allegations are cited at F279 and F323. Survey dates: January 9, 10, 2013 Extended survey dates: January 11, 12, 13, 14, 15, 2013 Facility number 000241 Provider number 155636 AIM number 100291310 Survey team: Chuck Stevenson RN Census bed type: SNF/NF: 105 Total: 105 Census payor type: Medicare: 7 Medicaid: 89 Other: 9 Total: 105 Sample: 3 Supplemental sample: 2	F0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegationof Compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review 1/18/13 by Suzanne Williams, RN			

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F0279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview, the facility failed to ensure a resident's safety and psychosocial needs were met by not developing comprehensive care plans in a timely manner for a resident (Resident E) with sexually inappropriate, physically and verbally aggressive, and intrusive wandering behaviors and who was determined to require one on one staffing for the safety of the resident and other residents, for 1 of 3 residents reviewed for care plans in a sample of 3.	F0279	F279 A comprehensive care plan has been developed for the resident affected by the alleged deficient practice. Residents who exhibit new or worsening behaviors have the potential to be affected by the alleged deficient practice. All other residents with sexually inappropriate, physically and verbally aggressive, and intrusive wandering behaviors, care plans were reviewed to ensure residents had a comprehensive care plan to address the	02/08/2013

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	Findings include: 1. The record of Resident E was reviewed on 01/10/13 at 3:00 p.m. Diagnoses included, but were not limited to, Down's syndrome, dementia, gastro esophageal reflux disease, hyperlipidemia, and celiac disease. An admission Minimum Data Set (M.D.S.) assessment dated 12/18/12 indicated Resident E was significantly cognitively impaired, was unable to complete an interview to assess his mood, had no behaviors, ambulated with assistance, and required staff assistance for activities of daily living. Documentation indicated Resident E was admitted to the facility on 12/11/12. Progress Notes for Resident E indicated: 12/20/12 5:46 A.M.: "The resident was observed kissing another female resident in (sic) the mouth and it was not consensual. The resident was also observed inappropriately (sic) touching the resident. The resident was immediately removed and told the behavior was unacceptable. The		behaviors. An inservice on Behavior Management including sexually inappropriate behaviors was provided to staff by the Staff Development Coordinator on 1/11-13/2013. Staff will call the DNS when any physically aggressive, verbally aggressive or sexually inappropriate behaviors occur that is directed to another resident. An immediate intervention will be put into place at that time. Nurses will conduct a shift to shift report on any new behavior management interventions – relaying the interventions to licensed and unlicensed staff. CNA assignment sheets are updated during IDT meeting. During weekends the weekend supervisor will update CNA assignment sheets. The IDT will review interventions to evaluate the effectiveness and to ensure there is no reoccurrence. The behavior monitoring flow sheet will be completed every shift, and reviewed by the unit managers to ensure care plan interventions were implemented. New and worsening behaviors will be reviewed by the IDT on the next business day. Interventions will be identified. The care plans and care sheets will be updated at that time. To ensure compliance, the DNS/Designee is responsible for the completion of the Behavior	

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	resident became verbally aggressive and stated, 'Make me stop you old goat'..." 12/20/12 6:45 P.M.: "Group of Xmas (Christmas) caroler's (sic) here on unit singing Xmas carol's (sic). Res (resident) attempted to walk up to visitor with lips puckered for a kiss. This writer immediately got between res et (and) visitor et removed res away from visitor. Other res started yelling (symbol for "at") this res to sit down and be quiet..." 12/20/12 9:37 P.M.: "Res cont (continued) to have behaviors this shift, res walked up to a female res et exposed his (sic) self by holding his penis in his hand et laughing (symbol for "at") res...When this writer assisted res to bed started (sic) trying to kiss this writer. This writer immediately explained to res that he should not kiss anyone, or expose himself to anyone. Res stated 'make me. Res put on 15 min (minute) chk's (checks) for behaviors." 12/21/12 10:02 A.M."IDT (Interdisciplinary Team) met to discuss residents (sic) new and or worsening behavior that occurred on 12/19/12, 12/20/12, and 12/21/12. Throughout these days resident was		Management CQI tool weekly times 4 weeks, bi-monthly times 2 months and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	noted to have been intrusively wandering in and out of other residents (sic) rooms, throwing his meal beverages on the floor as well as eat (sic) others (sic) foods, exposing himself to other residents, becoming verbally and physically aggressive toward staff, attempting to kiss and touch visitors that came on to the unit and kissing resident (number of resident) without her consent...Staff interventions were unsuccessful. Resident continued to exhibit behaviors until he was assisted to bed..." 12/23/12 1:56 A.M.:"...returned to this unit (Mapleton) early evening, Bx. (behaviors) began almost immed., (immediately) ambulated to other resident rooms and entered, residents began to yell..." 12/26/12 10:55 A.M.: "Res wandered into room (a room on the Chatham Arch unit) and res (Resident F) redirected this res out to hallway. When this res attempted to go back into rm (room) res (Resident F) made contact with this res left side of face....Started 15 minute checks for safety." Resident E's record contained no documentation of 15 minute checks.			

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	On 01/13/13 at 10:30 A.M. the Executive Director indicated he had no documentation of 15 minute checks being performed. 12/27/12 7:01 P.M.:"...res has been intrusively wandering into res rooms and space continuously this shift, res has taken things from peers and worn their clothing, becomes agitated when staff attempts to redirect him and return his peers (sic) belongings, yelling and cursing..." 12/28/12 5:19 P.M.: "Transferred to room (on Chatham unit) res continues to wander in and out of peers (sic) rooms, taking their belongings, arguing with staff when redirected..." 12/31/12 10:30 A.M.: "Resident cont (continues) to wander in and out of other residents (sic) rooms and take their belongings. Staff redirects resident but this causes an increase in agitation on residents (sic) part. At 10:15 a.m., resident was walking in hall by nurses station. A female resident walking in the other direction stopped in front of res and reached out to touch him on his arm. Res then raised his fist and made contact with the face of the female resident. Staff immediately separated the two. The resident has been placed on constant			

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	obs (observation). Family has been called and is attempting to arrange someone to come in and sit with him awhile to calm him down." Resident E's record contained no documentation of constant observation. On 1/13/13 at 10:30 A.M. the Executive Director indicated he had no documentation of constant observation being performed. 1/01/13 2:59 P.M.: "...res has been wandering in and out of res rooms taking their belongings, putting their clothes on, taking clothes out of drawers throwing them all over the room, yelling and taking things off the linen cart stuffing them in his pants..." 1/02/13 2:17 P.M.: "res acting very inappropriate during breakfast res yelling, mocking other residents, asking female staff for a kiss, putting his fists up in the air as if he wants to fight people, wandering in and out of other res rooms taking their belongings and putting others clothes on. It is very difficult to redirect resident he yells and screams when redirected causing a big scene..." 1/03/13 2:32 A.M.: "Resident observed taking clothes out of roommates (sic) drawers and			

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	chest...he became verbally aggressive using profanity...also continues to pull penis out and show it to staff..." 1/04/13 8:30 A.M.: "Resident attempted to kiss a female resident on the mouth...Res was redirected to dining room...when writer left his side for about 3 minutes to obtain meds (medications) from cart, res approached a female resident from behind and pulled out his penis. He then began to try to rub it on female residents (sic) buttocks..." 1/05/13 11:14 A.M.: "...stood behind hospice aide and pantomimed sexual jestures (sic) with his hips while patting his genitals...then unfastening his pants..." 1/06/13 4:59 P.M.: "Resident cont (continues) with hoarding behaviors in spite of attempts to redirect. At breakfast, resident mocked another resident by repeating everything the other was saying to staff. When asked to quit, Res responded by saying 'Your momma is ugly' and flipping his middle fingers first at res then at staff. The two had to be separated when the other became angry and swung at res without making contact. In addition, res			

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	swung a belt at an aides (sic) head today. When cat in the hole was failing to get staff attention, res began yelling p---y and laughing." 1/07/13 11:05 A.M.: "Res noted by this writer to have another residents (sic) stereo headphones tucked down the front of his pants. Approached res and stated that I need to see those so they did not get broken. Res immediately began yelling 'No, they are mine" and took the headphones out and held them behind his back. When writer reached for headphones, res swung fist and attempted to make contact with staff members (sic) face...Res escorted from the female residents (sic) room where this occurred..." 1/08/13 3:02 P.M.: "Res was wandering in and out of other res rooms this shift taking their belongings, trying to box with the staff when redirected, when asked to not do certain things res states, 'who's gonna make me?' and res was also caught trying to hump one of the female residents in the hallway. That behavior was stopped immediately by a staff member. Res is now on another unit (Brickyard, an all male unit) for the day and will return after dinner to go to bed. "			

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	On 1/14/13 at 2:45 P.M. the Executive director provided documentation of Resident E's care plans. He indicated this was a complete, accurate, and up to date copy of all care plans in place for Resident E. Resident E's record contained no care plan for one on one staffing. Existing care plans had no interventions related to one on one staffing. Resident E's problematic behaviors, as documented in progress notes above, began on 12/20/12 at 5:46 A.M., when he was observed kissing and inappropriately touching a female resident against her wishes. On 12/20/12 at 6:45 P.M. he was observed trying to kiss a visitor. On 12/20/12 at 9:37 P.M. he exposed himself to a female resident. An Interdisciplinary Team meeting note of 12/21/12 at 10:02 A.M. indicated he had behaviors including intrusive wandering, throwing food and beverages, exposing himself, becoming physically and verbally aggressive, and attempting to kiss and touch female residents and visitors. These behaviors continued as documented above.			

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Care plans for Resident E's problematic behaviors, with problem start dates, were as follows:

"Problem: Behavioral Symptoms: At times resident will eat other residents (sic) food and or drink." Problem start date: 12/31/12.

"Problem: Behavioral Symptoms: Resident will expose himself to others as well as attempt to kiss and inappropriately touch others." Problem start date: 12/31/12.

"Problem: Behavioral Symptoms: Resident will yell, curse, and make sexually inappropriate comments at others especially during periods of attention seeking and when others use corrective language such as 'don't' 'do' 'no' ect. (sic) Problem start date: 12/31/12.

"Problem: Behavior: Resident will intrusively wander in and out of other's rooms in order to remove items such as clothing he will layer over his own clothing." Problem start date: 01/11/13.

"Problem: Behavior: Resident will hit, spit and make sexually inappropriate gestures at others especially during

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	periods of attention seeking and when others use corrective language such as 'don't' 'do' 'no' ect. (sic) Problem start date: 1/11/13. A facility policy titled "Care Plan Review and Maintenance Process," received from the Director of Nursing Services on 1/15/13 at 10:20 A.M., and most recently revised on 8/11, indicated: "Policy: It is the policy of this facility that each resident will have a comprehensive care plan developed based on comprehensive assessments. The care plan will include measurable goals and resident specific interventions based on resident needs and preferences to promote the residents (sic) highest level of functioning including medical, nursing, mental and psychosocial needs. Procedure:...Care plan problems, goals and interventions will be updated based on changes in resident assessment/condition, resident preferences or family input." An undated facility policy, titled "(Initials for facility's parent company) Behavior Management Policy and Procedures," received from the			

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	Director of Nursing Services on 1/15/13 at 10:20 A.M. and indicated to be a current facility policy, indicated: "Policy: It is the policy of (name of parent company) to provide behavior interventions and monitoring for residents with problematic or distressing behaviors. Interventions provided are both individualized and non pharmacological and part of a supportive physical and psychosocial environment that is directed toward preventing, relieving and/or accommodating a resident's distressed behavior. Procedure: Care plans should be initiated for any behavioral issues that affects, or has the potential to affect, the resident or other residents... Care should be taken to ensure that interventions and behaviors are changed on the care plan...." This federal tag relates to complaint IN00121723. 3.1-35(a)			

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F0323 SS=K	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to provide adequate supervision to protect residents from behaviors of a newly admitted resident (Resident E) that were sexually inappropriate, and physically and verbally aggressive, and intrusive wandering behaviors, and to protect the newly admitted resident from physically and verbally aggressive reactions of residents to his behavior, for 1 of 3 residents reviewed for behaviors in a sample of 3. This deficient practice potentially affected 29 residents on the Mapleton unit and 22 residents on the Chatham Arch unit. This deficient practice resulted in Immediate Jeopardy. The Immediate Jeopardy was identified on 1/10/13 and began on 12/20/12. The Executive Director and Director of Nursing Services were notified of the Immediate Jeopardy on 01/10/13 at 4:45 P.M. The Immediate Jeopardy was removed on 01/13/13, but the facility remained out of compliance at	F0323	F 323 Resident E was placed on one to one supervision continuously and was relocated to reside on the all male unit on 1/10/13. He continues to reside on the all male unit and is on continuous one to one supervision at all times as long as the resident remains in the facility. Residents who reside in the facility have the potential to be affected by the alleged deficient practice. All other residents with sexually inappropriate, physically and verbally aggressive, and intrusive wandering behaviors, care plans were reviewed to ensure residents had a comprehensive care plan to address the behaviors. An inservice on Behavior Management including sexually inappropriate behaviors was provided to staff by the Staff Development Coordinator on 1/11-13/2013. Staff will call the DNS when any physically aggressive, verbally aggressive or sexually inappropriate behaviors occur that is directed to another resident. An immediate intervention will be put into place at that time. Nurses will conduct a shift to shift report on any new	02/08/2013

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	the level of pattern, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy, because the facility still needs to ensure all residents with behaviors potentially affecting other residents have current and appropriate assessments, health care and behavior plans have been reviewed and updated, and appropriate interventions and supervision are in place for all residents. Findings include: 1. The record of Resident E was reviewed on 01/10/13 at 3:00 p.m. Diagnoses included, but were not limited to, Down's syndrome, dementia, gastro esophageal reflux disease, hyperlipidemia, and celiac disease. An admission Minimum Data Set (M.D.S.) assessment dated 12/18/12 indicated Resident E was significantly cognitively impaired, was unable to complete an interview to assess his mood, had no behaviors, ambulated with assistance, and required staff assistance for activities of daily living. Documentation indicated Resident E was admitted to the facility on		behavior management interventions – relaying the interventions to licensed and unlicensed staff. CNA assignment sheets are updated during IDT meeting. During weekends the weekend supervisor will update CNA assignment sheets. The IDT will review interventions to evaluate the effectiveness and to ensure there is no reoccurrence. The behavior monitoring flow sheet will be completed every shift, and reviewed by the unit managers to ensure care plan interventions were implemented. New and worsening behaviors will be reviewed by the IDT on the next business day. Interventions will be identified. The care plans and care sheets will be updated at that time. To ensure compliance, the DNS/Designee is responsible for the completion of the Behavior Management CQI tool weekly times 4 weeks, bi-monthly times 2 months and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	12/11/12. Progress Notes for Resident E indicated: 12/20/12 5:46 A.M.: "The resident was observed kissing another female resident in (sic) the mouth and it was not consensual. The resident was also observed inappropriately (sic) touching the resident. The resident was immediately removed and told the behavior was unacceptable. The resident became verbally aggressive and stated, 'Make me stop you old goat'...." 12/20/12 6:45 P.M.: "Group of Xmas (Christmas) caroler's (sic) here on unit singing Xmas carol's (sic). Res (resident) attempted to walk up to visitor with lips puckered for a kiss. This writer immediately got between res et (and) visitor et removed res away from visitor. Other res started yelling (symbol for "at") this res to sit down and be quiet..." 12/20/12 9:37 P.M.: "Res cont (continued) to have behaviors this shift, res walked up to a female res et exposed his (sic) self by holding his penis in his hand et laughing (symbol for "at") res...When this writer assisted res to bed started (sic) trying			

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	to kiss this writer. This writer immediately explained to res that he should not kiss anyone, or expose himself to anyone. Res stated 'make me. Res put on 15 min (minute) chk's (checks) for behaviors." 12/21/12 10:02 A.M."IDT (Interdisciplinary Team) met to discuss residents (sic) new and or worsening behavior that occurred on 12/19/12, 12/20/12, and 12/21/12. Throughout these days resident was noted to have been intrusively wandering in and out of other residents (sic) rooms, throwing his meal beverages on the floor as well as eat (sic) others (sic) foods, exposing himself to other residents, becoming verbally and physically aggressive toward staff, attempting to kiss and touch visitors that came on to the unit and kissing resident (number of resident) without her consent...Staff interventions were unsuccessful. Resident continued to exhibit behaviors until he was assisted to bed..." 12/23/12 1:56 A.M.:"...returned to this unit (Mapleton) early evening, Bx. (behaviors) began almost immed., (immediately) ambulated to other resident rooms and entered, residents began to yell..."			

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	12/26/12 10:55 A.M.: "Res wandered into room (a room on the Chatham Arch unit) and res redirected this res out to hallway. When this res attempted to go back into rm (room) res made contact with this res left side of face....Started 15 minute checks for safety." Resident E's record contained no documentation of 15 minute checks. On 1/13/13 at 10:30 A.M. the Executive Director indicated he had no documentation of 15 minute checks being performed. 12/27/12 7:01 P.M.:"...res has been intrusively wandering into res rooms and space continuously this shift, res has taken things from peers and worn their clothing, becomes agitated when staff attempts to redirect him and return his peers (sic) belongings, yelling and cursing..." 12/28/12 5:19 P.M.: "Transferred to room (on Chatham unit) res continues to wander in and out of peers (sic) rooms, taking their belongings, arguing with staff when redirected..." 12/31/12 10:30 A.M.: "Resident cont (continues) to wander in and out of other residents (sic) rooms and take			

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	their belongings. Staff redirects resident but this causes an increase in agitation on residents (sic) part. At 10:15 a.m., resident was walking in hall by nurses station. A female resident walking in the other direction stopped in front of res and reached out to touch him on his arm. Res then raised his fist and made contact with the face of the female resident. Staff immediately separated the two. The resident has been placed on constant obs (observation). Family has been called and is attempting to arrange someone to come in and sit with him awhile to calm him down." Resident E's record contained no documentation of constant observation. On 1/13/13 at 10:30 A.M. the Executive Director indicated he had no documentation of constant observation being performed. 1/01/13 2:59 P.M.: "...res has been wandering in and out of res rooms taking their belongings, putting their clothes on, taking clothes out of drawers throwing them all over the room, yelling and taking things off the linen cart stuffing them in his pants..." 1/02/13 2:17 P.M.: "res acting very inappropriate during breakfast res yelling, mocking other residents,			

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	asking female staff for a kiss, putting his fists up in the air as if he wants to fight people, wandering in and out of other res rooms taking their belongings and putting others clothes on. It is very difficult to redirect resident he yells and screams when redirected causing a big scene..." 1/03/13 2:32 A.M.: "Resident observed taking clothes out of roommates (sic) drawers and chest...he became verbally aggressive using profanity...also continues to pull penis out and show it to staff..." 1/04/13 8:30 A.M.: "Resident attempted to kiss a female resident on the mouth...Res was redirected to dining room...when writer left his side for about 3 minutes to obtain meds (medications) from cart, res approached a female resident from behind and pulled out his penis. He then began to try to rub it on female residents (sic) buttocks..." 1/05/13 11:14 A.M.: "...stood behind hospice aide and pantomimed sexual jestures (sic) with his hips while patting his genitals...then unfastening his pants..." 1/06/13 4:59 P.M.: "Resident cont			

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	(continues) with hoarding behaviors in spite of attempts to redirect. At breakfast, resident mocked another resident by repeating everything the other was saying to staff. When asked to quit, Res responded by saying 'Your momma is ugly' and flipping his middle fingers first at res then at staff. The two had to be separated when the other became angry and swung at res without making contact. In addition, res swung a belt at an aides (sic) head today. When cat in the hole was failing to get staff attention, res began yelling p---y and laughing." 1/07/13 11:05 A.M.: "Res noted by this writer to have another residents (sic) stereo headphones tucked down the front of his pants. Approached res and stated that I need to see those so they did not get broken. Res immediately began yelling 'No, they are mine' and took the headphones out and held them behind his back. When writer reached for headphones, res swung fist and attempted to make contact with staff members (sic) face...Res escorted from the female residents (sic) room where this occurred..." 1/08/13 3:02 P.M.: "Res was wandering in and out of other res			

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	rooms this shift taking their belongings, trying to box with the staff when redirected, when asked to not do certain things res states, 'who's gonna make me?' and res was also caught trying to hump one of the female residents in the hallway. That behavior was stopped immediately by a staff member. Res is now on another unit (Brickyard, an all male unit) for the day and will return after dinner to go to bed. " A physician's order dated 1/04/13 at 10:20 A.M. indicated Resident E was to receive Depo Provera (a birth control medication prescribed for men to reduce sexually impulsive behavior) 400 milligrams by injection once a month. During an interview with the Administrator on 01/11/13 at 9:45 A.M. he indicated that the Mapleton unit was for residents with mild to moderate dementia, and that the Chatham Arch unit was for residents with more advanced dementia. He also indicated the Chatham Arch unit was more appropriate for residents with wandering behavior as the residents there were less likely to be aware of the behavior, and indicated the Brickyard unit was a male only unit for residents with problematic			

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	behaviors. During an interview with the Administrator and Director of Nursing on 01/11/13 at 10:45 A.M., it was indicated, and documentation was provided, the Resident E had been a resident on the Mapleton unit from 12/11/12 through 12/31/12, and resided on the Chatham Arch unit from 12/31/12 through 01/10/13. During an interview on 01/14/13 at 2:00 P.M. the Business Office Manager indicated this was incorrect, that Resident E had actually moved to the Chatham Arch unit on 12/28/12. It was noted that he spent daytime hours on the Brickyard unit on 12/21/12, 12/22/12, 12/23/12, and 12/24/12. He continued to reside on the Chatham Arch unit through this time. He was transferred to the Brickyard unit on the evening of 01/10/13 when he returned from a leave of absence with family. An undated facility document titled "(Initials for facility's parent company) Behavior Management Policy and Procedure," received from the Director of Nursing Services on 1/15/13 at 10:20 A.M., and indicated to be a current facility policy, indicated:			

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	"Policy: It is the policy of (name of parent company) to provide behavior interventions and monitoring for residents with problematic or distressing behaviors. Interventions provided are both individualized and non pharmacological and part of a supportive physical and psychosocial environment that is directed toward preventing, relieving and/or accommodating a resident's distressed behavior." An Immediate Jeopardy was identified on 1/10/13 at 4:00 p.m. The Immediate jeopardy began on 12/20/12 when Resident E was observed kissing and inappropriately touching a female resident against her wishes and later exposed himself to a female resident. The Executive Director and Director of Nursing Services were notified on 1/10/13 at 4:45 P.M. of the Immediate Jeopardy related to lack of supervision to prevent verbally and physically and sexually inappropriate behaviors. The Immediate Jeopardy was removed on 01/13/13, when through observations, interviews and record reviews, it was determined the facility had implemented the plan of action to remove the immediacy of the problem. The resident was transferred to an all male secured			

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	unit, was placed on continuous one on one staffing, and staff were updated on new behavior management strategies. The Unit Manager and one on one attending staff were interviewed and adequately expressed understanding of the situation. They noted the resident had no notable behaviors since starting one on one staffing. The resident was observed multiple times over a 3 day period and no behaviors were observed. The facility instituted a log for caregivers to enter notes every 15 minutes and this was being followed. Even though the facility's corrective action removed the Immediate Jeopardy, the facility remained out of compliance at the level of pattern, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. This federal tag relates to complaint IN00121723. 3.1-45(a)(2)			